Application for
PFL LIFE INSURANCE COMPANY
BAPP

Life Insurance

FOR HOME OFFICE USE ONLY
Number

Special Request

PLAN OF INSURANCE: Term
PREMIUM AMOUNT
FACE AMT./ SPEC AMT.
☒ Level 1 ☐ Level 2
Soc. Security # (Applicant) 418 02 2367

BENEFITS: ☐ ADD ☐ ALB ☐ ☐

DIVIDEND OPTION
☐ Accumulate at Interest (Automatic Option)
☐ Paid in Cash
☐ Paid up Additions

OWNERSHIP (Life Insurance Only)
(COMPLETE ONLY IF OTHER THAN PRIMARY APPLICANT)
A. OWNER'S NAME
B. ADDRESS
C. CITY, STATE, ZIP
D. OWNER'S SOCIAL SECURITY NO.
E. OWNER'S DATE OF BIRTH MO____ DAY____ YR____
AUTOMATIC PREMIUM LOAN (if available) ☐ YES ☐ NO

Health Insurance

PMH Deductible
☐ $ 250
☐ $ 500
☐ $ 750
☐ $ 1,000
☐ $ 1,250
☐ $ 1,500
☐ $ 1,750
☐ $ 2,000
☐ $ 2,500
☐ $ 5,000

Health Insurance Applied For:

GHP6 MAX BENEFIT
☐ $500,000
Ded. $ _____

DAILY BENEFIT
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $___
Ded. $ _____
☐ GHP7 ☐ GHP8

GHP8
☐ 100%
☐ 80/20
☐ 50/50
☐ _____
Ded. ☐ $600
☐ $1,200
☐ $2,400
☐ $_____

☐ PPO ☐ EPO
PPO Copay Options
☐ $10 ☐ A
☐ 15 ☐ B
☐ 20 ☐ C
☐ 25 ☐ D
☒ Rx
☐ Vision
☐ Other

OTHER COVERAGE (if any) Amount Add'l Premium
☐ Accident Benefit $ 500 $ Inc
☐ Childbirth Benefit $ _____ $ Inc
☐ OP Chemo. Benefit $ Inc
☐ Ret. of Prem. Ben. $ _____
☐ Test./Therapy Ben. 10/copay $ Inc
☐ Outpatient Care Opt.(Ded) $ _____ $ _____
☐ Cat. Expense Ben. (Ded.) $ _____ $ _____
☐ Accident Waiver Ben. $ _____
☐ Double Misc. Ben. $ _____ $ _____
☐ Triple Misc. Ben. $ _____ $ _____
☐ Double Surg. Ben. $ _____ $ _____
☐ Triple Surg. Ben. $ _____ $ _____
☐ Life Ins. Benefit Rider $ _____ $ _____
☐ Prescription Drug Rider $ _____
☐ Other $ _____ $ _____
Total Additional Premium $ _____

Social Security # (Applicant) 418 02 2362

Dental Insurance

☒ YES ☐ NO
If applying for Dental Insurance, is any Proposed Insured person in the full-time service in the armed forces (other than for training for a period not to exceed 60 days)?
☐ YES ☐ NO
If yes, list name(s)

418 02 2367

Soc. Security # (Applicant) 418 02 2367

Disability Income Insurance

☐ Disability Income
Amount $ _____
Elimination Period _____
Benefit Period _____
Occ. Class _____

Soc. Security # (Applicant)

Other Coverage (if any) Add'l. Prem.
☐ AD & D _____ $ _____
☐ Return of Premium _____ $ _____
☐ Hospital Conf. _____ $ _____
☐ Business Overhead _____ $ _____
Mo. Max. $ _____
Elim. Prd. $ _____
☐ Other _____ $ _____
Total Add'l. Premium _____ $ _____

Accident Insurance

DAILY BENEFIT-GACC7
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $ _____
Ded. $ _____

GACC8
☐ 100%
☐ 80/20
☐ 50/50
☐ _____
Ded. ☐ $600
☐ $ _____
☐ $2,400
☐ $ _____

Social Security # (Applicant)

OTHER COVERAGE (if any)

	Amount	Add'l Premium
☐ Accident Benefit	$ _____	$ _____
☐ Double Misc. Ben.	$ _____	$ _____
☐ Triple Misc. Ben.	$ _____	$ _____
☐ Double Surg. Ben.	$ _____	$ _____
☐ Triple Surg. Ben.	$ _____	$ _____
☐ Spc. Dis. & Emerg. Med. Care Benefit	$ _____	$ _____
☐ Acc. & Spc. Dis. OP Therapy Benefit	$ _____	$ _____
☐ Other	$ _____	$ _____
Total Additional Premium	$ _____	$ _____

BENEFICIARY
PRIMARY Troy M. Tillerson
RELATIONSHIP Father
SOCIAL SECURITY # 416 18 8965
CONTINGENT Carol J. Owens
RELATIONSHIP Mother
SOCIAL SECURITY #

6900-AG (794)

TI000059

SECTION A — COMPLETE THIS SECTION FOR ALL APPLICATIONS

1. *PRINT* name of applicant and each member of the family (including wife's maiden name)

	Name	Relationship	State of Birth	Sex	Date of Birth Mo.	Day	Yr.	Present Age	Height	Weight Now	Weight 1 Yr. Ago	Premium
(1)	Troy E. Tillerson	Applicant	AL	M	3	22	64	32	6'	235	235	
(2)		Spouse										
(3)												
(4)												
(5)												
(6)												

Pay mode: Monthly ☒ Quarterly ☐ Semi-Annually ☐ Annual ☐ Total Premium ______

Insurance applied for: Life = L Health = H Dental = Den Disability Income = Dis Accident = A Rx Drug = Rx Vision = V
Member # (1) Applicant H, L, Rx, D (2) Spouse ______ (3) ______ (4) ______ (5) ______ (6) ______

2. Addresses: Number and Street or R.F.D. City State Zip Telephone

☐ a. Permanent U.S. Residence 459 S. [illegible] Hill Rd [illegible] AL 35[illegible] ([illegible]) [illegible]

b. Business Name Alabama Home Inspection

☐ c. Business Address Same

3. a. Primary Occupation: (Member 01) Home Inspector

b. Duties (describe in detail): Inspects Homes

c. List any other occupations, second jobs or part-time jobs and your duties:

SECTION B — COMPLETE THIS SECTION FOR HEALTH, LIFE, DISABILITY INCOME AND ACCIDENT

Yes No

4. I am a member of the National Association for the Self Employed .... ☒ ☐

5. Are any family members covered under Medicaid or Medicare? .... ☐ ☒

Name(s) ______

6. Has any person proposed for insurance:

a. Ever had an application or reinstatement for life, disability income or accident and sickness insurance declined, postponed, rated up, modified, or terminated? .... ☐ ☒

b. Had a drivers license suspended or revoked in the last two years? .... ☐ ☒

Give details if any question is answered "Yes": ______

7. Are all children or stepchildren of the Applicant proposed for insurance by this Application, currently unmarried and under the age of nineteen (19) years and residing at the Applicant's principal place of residence; or under the age of twenty-four (24) years and enrolled as a full-time student at an accredited college or university? .... ☐ ✓
If answer is "No," give name(s) and reason:

8. During the past two years, has any person proposed for insurance: Flown in any aircraft other than as a passenger, engaged in any racing, parachuting, scuba diving activities, or other hazardous avocations or does he/she intend to do so in the next 12 months? .... ☒ ☐
If "Yes," give details: Scuba Diving - for 9yrs Stays above 1 Atmosphere

SECTION C — COMPLETE THIS SECTION FOR HEALTH, LIFE AND DISABILITY INCOME

9. Family Physician/Physician who would have medical records:

a. For Applicant: Name Dr Mark Hayden Address 26297 Tallassee Hwy
City Wetumpka State AL Zip 36092 Telephone No: (334) 5[illegible]
Date last seen 1996 Reason Cold

b. For Spouse: Name ______ Address ______
City ______ State ______ Zip ______ Telephone No: ( ) ______
Date last seen ______ Reason ______

c. For Children: Name ______ Address ______
City ______ State ______ Zip ______ Telephone No: ( ) ______
Date last seen ______ Reason ______

SECTION C CONT'D — COMPLETE THIS SECTION FOR HEALTH, LIFE, AND DISABILITY INCOME

	Yes	No
10. Within the past 5 YEARS has any person proposed for insurance:		
a. Had or been advised to have a surgical operation, electrocardiogram, x-ray or other diagnostic test?	☐	☑
b. Been in or advised to enter a hospital or other institution for consultation, examination or treatment?	☐	☑
c. Consulted or been examined by any physician or other practitioner?	☑	☐
d. Used sedatives, hallucinogenic or narcotic drugs other than those prescribed by a physician or received treatment for a drug habit?	☐	☑
e. Received treatment or advice for excessive use of alcohol?	☐	☑
11. Is any family member now pregnant?	☐	☑
12. Has any person proposed for insurance used any tobacco products within the past 12 months?	☑	☐
13. Has any person proposed for insurance ever been rejected or deferred for military service?	☐	☑
14. Is any proposed insured presently under observation or taking treatment?	☐	☑
15. Has any person proposed for insurance EVER had any indication, diagnosis, or treatment of:		
a. The brain or nervous system, including but not limited to dizziness, fainting, migraines, convulsions, paralysis, stroke, mental or nervous disorder?	☐	☑
b. The respiratory system, including but not limited to shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☑
c. The heart or blood vessels, including but not limited to chest pain, blood pressure, rheumatic fever, heart murmur, heart attack, varicose veins, or other disorder of the heart or blood vessels?	☐	☑
d. The gastro-intestinal tract, liver or pancreas, including but not limited to jaundice, intestinal bleeding, ulcer, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☑
e. The genito-urinary organs, including but not limited to albumin, blood or pus in urine, stone or other disorders of kidney, urinary bladder, or prostate?	☐	☑
f. The eyes, ears, nose or throat?	☐	☑
g. Diabetes or elevated blood sugar, thyroid or other glandular disorder, including but not limited to lymph glands?	☐	☑
h. Neuritis, arthritis, gout, disorder of the muscles or bones, including but not limited to spine, back, or joints?	☐	☑
i. Complications of pregnancy and/or cesarean section?	☐	☑
j. Deformity, lameness or amputation?	☐	☑
k. Cyst, tumor, cancer, or growth of any kind?	☐	☑
l. Allergies, anemia or other disorders of the blood?	☐	☑
m. Disease or disorder of the reproductive organs or breasts?	☐	☑
16. Has any person proposed for insurance EVER been diagnosed or treated for any disorder or dysfunction of the blood system or immune system including but not limited to Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or Lymphadenopathy Syndrome?	☐	☑

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 10 THRU 16

Ques. No.	Person No.	Nature of Injury, Sickness, Disease, Impairment or Physical Condition	Date	Hospitalization Required? Yes	No	Date	Surgery Performed? Yes	No	Date	Name and Address of Physician and Hospital
12	1	Cold Complete Recovery	1996		☑			☑		Dr. Hayden

17a. List below all life, health and disability income insurance currently in force or that you have applied for in the last six months. **If none, state none.**

#	COMPANY NAME	TYPE of COVERAGE	LIFE INS. AMOUNT	DISABILITY BENEFIT AMOUNT	DISABILITY BENEFIT PERIOD	DISABILITY ELIM. PERIOD	Status Applied for	In Force Standard	In Force Substandard
1	None						☐	☐	☐
2							☐	☐	☐
3							☐	☐	☐
4							☐	☐	☐
5							☐	☐	☐

b. Which of the above will be changed, terminated, not taken, or replaced by coverage(s) that you are applying for on this application. ☐ **If None, check here.**

FROM 17.a	DATE OF CHANGE OR TERMINATION	DETAILS-IF CHANGE

SECTION D COMPLETE THIS SECTION FOR LIFE AND DISABILITY INCOME

18. Annual earned income from personal services (after business expenses, if any) as you reported on your Federal Income Tax Return:

	Last Year	Current Year (est.)
Salary, Draw, Professional Fees	$	$
Other (describe):	$	$
TOTAL	$	$

19. List your unearned income from investments or other sources (e. g., dividends, interest, net rental income, pensions, alimony, etc.):

Last Year	Current Year (est.)
$	$

SECTION E COMPLETE THIS SECTION IF APPLYING FOR BUSINESS OVERHEAD EXPENSE RIDER

20. a. What is the Applicant's share of the overhead expenses? _____ %

b. List below the total monthly expenses of the business entity for which you are liable:

Rent/Mortgage Payment	$	Vehicle, Machinery, Equipment Rental	$	Interest on Business Loans	$
Utilities (Electricity Telephone, Heat)	$	P & C Insurance	$	Employees Salaries (other than family)	$
Ad Valorem Taxes on Business Equipment Property	$				

TOTAL COVERED	$
Other Expenses	$
TOTAL EXPENSES	$

21. a. How many people are employed by this company? (Include the Applicant in the total)

Owners: Full-time _____ Part-time _____

Employees: Full-time _____ Part-time _____

b. Do any of the above include spouse, parent, son, daughter, brothers or sisters of you or your spouse? ..... ☐ Yes ☐ No

If yes, indicate number of Owners _____ Employees _____

22. The Applicant's company is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation

☐ S Corporation-Date of Election ___ / ___ / ___ (Mo. / Day / Yr.) ☐ Other (Specify) _____

SECTION F COMPLETE THESE TWO QUESTIONS IF CHILD LIFE INSURANCE IS APPLIED FOR

1. If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives: (Attach additional page with information)

2. How much life insurance is carried by:
(a) Father _____ (b) Mother _____
(c) If this application is greater than (a) or (b) above: (Attach additional page with explanation)

TRUE AND COMPLETE

I understand each of the questions above and affirm that the recorded answers and statements are true and complete to the best of my knowledge and belief, and all information given to the agent has been recorded correctly and in its entirety.

_____
Signature of Applicant

DECLARATION AND AGREEMENTS

I agree that: (a) this Application will form a part of the contract; (b) the agent does not have the authority on behalf of the Company to accept risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; and (c) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting insurability are and have remained as described herein and the first premium has been paid in full. I understand any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is subject to criminal and/or civil penalties. I hereby acknowledge receipt of a copy of the Fair Credit Reporting Act and Medical Information Bureau notices.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give PFL Life Insurance Company, or its reinsurers, any such information. PFL Life Insurance Company may also release information about me to its reinsurer. I authorize PFL Life Insurance Company to obtain an investigative consumer report on me. A photographic copy of this authorization shall be as valid as the original.

I have truly and accurately recorded the information as supplied by Applicant and family members.

_____
Signature of Licensed Agent

A285
_____
Agent's Number

$ 25.00
_____
Amount Collected By Agent

I UNDERSTAND THAT COVERAGE IS NOT EFFECTIVE UNLESS AND UNTIL APPROVED AND ISSUED BY THE COMPANY

Dated at Decatur AL 1-9 1996
City State Month Date Year

Signed X _____ I 418 62 2367
Applicant (For and in behalf of above) Social Security #

Signed X _____ I _____
Spouse Social Security #

(300-AC) (794) **CHECK MUST ACCOMPANY APPLICATION**

TI000062

PFL LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Cedar Rapids, Iowa
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service 1-800-527-5504

CERTIFICATE OF INSURANCE

PREFERRED PROVIDER ORGANIZATION NETWORK PLAN

We agree to pay benefits according to the provisions of the Group Policy if an Insured Person incurs Covered Services resulting from:

INJURY or SICKNESS.

The attached enrollment application is part of the Certificate. Please read and check it carefully. This Certificate is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE CERTIFICATE

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Certificate to Us at Our Administrative Office in North Richland Hills, Texas within 10 days after You receive it. Upon receipt, we'll cancel Your coverage as of the Certificate Date, and You will receive a full refund of all the premiums You have paid.

This Certificate describes the principal provisions of, but does not constitute, the contract of insurance. The actual contract is available for inspection at the National Headquarters of the group policyholder during regular business hours.

Craig D. Vermeer
SECRETARY

William L. Busler
PRESIDENT

IMPORTANT MESSAGE TO OUR CERTIFICATEHOLDERS

Cancelling health insurance coverage and purchasing new coverage, on account of encouragement by any agent, is called replacement. Some states have laws which forbid any misrepresentation by any agent that may occur at the time of replacement. Beware of anyone who encourages You to replace this coverage without allowing You time to carefully investigate the replacement proposal, or discourages You from talking with a representative of the company whose coverage is being recommended for replacement. For Your protection, if You are encouraged to replace this coverage, We urge You to seek advice and to take the time to investigate any recommendation. Keep in mind that You can request changes in this coverage after its effective date.

INDEX

Any endorsements and/or riders will follow the General Provisions section.

TI000003

DUPLICATE

CERTIFICATE SCHEDULE

Name of Association Member: TROY E TILLERSON

Initial Premium:

Certificate Date: 07/26/1996

Certificate Number: 732246121

Mode of Payment: MONTHLY

Coverage provides for the utilization of a Preferred Provider Organization (PPO). Certain benefits are paid at different rates if the service is not provided by a participating member of the Preferred Provider Organization. See the DEFINITIONS section for the definition the Preferred Provider Organization, Preferred Provider and Non-Participating Provider.

The Preferred Provider Organization is: PRIVATE HEALTHCARE SYSTEMS, INC.

The Review Organization is: NONE – PRENOTIFICATION ONLY

The Telephone Number of the Review Organization is: (800) 530-4878

	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum Amount:	**$1,000,000**	**$500,000**
Plan Deductibles Per Calendar Year:		
Individual	**$0**	**$2,000**
Family	**$0**	**$6,000**
Out-of-Pocket Maximums per Calendar Year:		
Individual	**$2,000**	**$5,000**
Family	**$5,000**	**$12,000**
SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Physician		
Inpatient Visits	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Surgery	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Specialty Care Physician		
Inpatient Visits	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Anesthesia	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Surgery	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Hospital Inpatient Services		
Inpatient Services	**$1,000 plus 20% of the next $5,000**	**50% Coinsurance after Deductible**
Hospital Outpatient Services		
Outpatient Surgery (per admission)	**$1,000 plus 20% of the next $5,000**	**50% Coinsurance after Deductible**
Skilled Nursing Facility (per Admission)	**$1,000 plus 20% of the next $5,000**	**50% Coinsurance after Deductible**
Home Health Services	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Chemotherapy and Radiation Therapy (per course of treatment)	**$1,000 plus 20% of the next $5,000**	**50% Coinsurance after Deductible**
Dialysis	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Emergency Room	**$1,000 per admission**	**50% Coinsurance after Deductible**

TI000004

DUPLICATE

SERVICES	IN-NETWORK	OUT-OF-NETWORK
Other Services		
Ambulance	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Medical/Surgical Supplies	**$0 Coinsurance**	**50% Coinsurance after Deductible**
Outpatient Testing and Therapy Benefit Rider:		
Primary Care Physician Services		
Diagnostics	**$0 coinsurance**	**50% coinsurance after deductible**
Specialty Care Physician Services		
Diagnostics	**$0 coinsurance**	**50% coinsurance after deductible**
Outpatient Hospital Services		
Outpatient Rehabilitation	**$20 coinsurance**	**50% coinsurance after deductible**
Other Services		
Durable Medical Equipment/ Prosthetics	**$20 per device**	**50% coinsurance after deductible**
Accident	**$600**	
Chemotherapy Benefit Rider		
Inpatient Admissions or Procedures Performed Without Prior Authorization	25% of charges in addition to other cost sharing	25% of charges in addition to other cost sharing
Procedures Performed or Charges Incurred Beyond Approved Length of Stay	25% of charges in addition to other cost sharing	25% of charges in addition to other cost sharing

NOTE: Covered Dependents, if any, are named in he attached Application and/or in the other attached documents.

Group Policy No. 0028-GPPFL Association: National Association for the Self-Employed

TI000005

DUPLICATE

DEFINITIONS

Chemotherapy:

treatment using chemical substances, including chemicals used in hormonal therapy or immunotherapy, administered in a hospital by a physician or other medical professional qualified and authorized to administer such treatment for the purpose of modification or destruction of cancerous tissue. Checkups, physical examinations, treatment planning consultations, diagnostic or laboratory tests are not considered Chemotherapy.

Coinsurance:

the dollar amount or percentage of a Covered Charge that must be paid by an Insured Person. Coinsurance does **not** include Non-Covered Charges. Amounts paid by an Insured Person under Coinsurance are accumulated to satisfy the Out-of-Pocket Maximum per calendar year. The Out-of-Pocket Maximum amounts and Coinsurance amounts are shown on the Certificate Schedule. The dollar amounts of Coinsurance listed in the Certificate Schedule apply to each visit or procedure when applicable. The Coinsurance cannot exceed the Covered Charge.

Cost Sharing:

Your portion of all medical expenses.

Covered Charges:

the Regular Charges for the services and supplies described in the COVERED SERVICES section of this Certificate.

Covered Services:

the Hospital, Skilled Nursing Facility, Home Health Agency, Physician and other services and supplies for which benefits are provided while coverage is in force under the Group Policy and for which the Insured Person is legally obliged to pay.

Complications of Pregnancy:

A. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy, including but not limited to: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; or
B. Termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring within 24 weeks of conception.

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is involuntary and performed to save the life of the mother or unborn child.

Consultation:

Evaluation, diagnosis, or medical advice given without the necessity of a personal examination.

Cosmetic Surgery:

the surgical alteration of tissue for the improvement of appearance, which does not effect a substantial improvement or restoration of bodily function, except reconstructive surgery incidental to or following surgery:
(1) resulting from trauma, infection or other diseases of the involved part; or
(2) reconstructive surgery due to a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Date of Service:

all Hospital or Skilled Nursing Facility services received by a bed patient during a Hospital or Skilled Nursing Facility Admission are considered to be received by the patient on the date the Admission begins. Date of Service also means that the services of Physicians or other suppliers of medical goods and services received by a patient are considered to be received by the patient on the day the service is received from the Physician or other supplier of medical goods and services. Date of Service also means the day the services are received by a patient in a Hospital outpatient department, Same-Day Surgery Facility or Home Health Agency.

Deductible:

the amount of Covered Charges that an Insured Person must pay before the Group Policy pays any benefits for such charges. Deductible does **not** include Non-Covered Charges. There are seperate Deductibles for In-Network charges and Out-of-Network charges. Each must be satisfied each calendar year. The Deductible is deducted only once during any one calendar year for each Insured Person. However, once three Insured Persons have met their Deductibles in one calendar year, no further Deductibles must be met that year. Any Covered Expenses incurred by an Insured Person during the last three months of a calendar year, which are applied toward a Deductible for that year, will also be applied toward that Insured Person's Deductible for the following calendar year. The Deductibles for In-Network and Out-of-Network services are listed on the Certificate Schedule.

If more than one Insured Person is injured by the same accident, only one Deductible need be met.

Durable Medical Equipment:

equipment which is:

1. designed and able to withstand repeated use;
2. primarily and customarily used to serve a medical purpose;
3. generally not useful to an Insured Person in the absence of Sickness or Injury; and
4. suitable for use in the home.

Eligible Dependent:

Your lawful spouse and unmarried natural, adopted and step children who are under 19 years of age (the Limiting Age) and living in Your home. The Limiting Age is extended to age 24 if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Experimental or Investigational:

any treatment, procedure or prescription which We or Our designated Representative determine is not the conventional treatment, procedure or prescription provided for the Sickness, Injury or condition of the Insured Person, provided that a treatment, procedure or prescription, shall not be considered to be experimental if:

a. the published results of randomized clinical studies establish beyond a reasonable doubt that the treatment, procedure or prescription produces high response rates and survival rates than the conventional treatment, procedure or prescription for the same Sickness, Injury or condition; or
b. in the absence of such published results, We determine in Our sole and absolute discretion that the treatment, procedure or prescription produces higher response rates and survival rates than the conventional treatment, procedure or prescription for the same Sickness, Injury or condition.

Home Health Care Agency:

a public agency or private organization, or a subdivision of an agency or organization, which:

a. operates pursuant to law;
b. is regularly engaged in providing home health care under the regular supervision of a registered nurse;
c. maintains a daily medical record on each patient; and
d. provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the home health care.

An agency or organization which is approved to provide home health care for Medicare benefits will be deemed to be a home health care agency.

Hospice:

a facility which provides limited periods of inpatient stay for terminally ill persons in a home-like setting. It must operate as part of a Hospice Care Program and be licensed, certified or registered in accordance with state law.

Hospice Care Program:

a formal program of care for terminally ill patients provided through:

(1) an inpatient Hospice stay; or
(2) an organized system of home care which: (a) is directed by a Physician; (b) uses a Hospice Team; and (c) is available to the patient on a 24-hour basis.

The Program must: (a) meet standards set by the National Hospice Organization; (b) be approved by Us; and (c) be licensed, certified or registered by the state, if required.

Hospice Team:

a team including a Physician and registered nurse (R.N.) that specializes in supportive care of terminally ill persons and their families. It may also include a social worker, clergyman, counselor, clinical psychologist, physiotherapist or an occupational therapist.

Hospital:

an institution operated pursuant to law for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay in the absence of insurance. The institution must:

(1) maintain, on the premises, organized facilities for medical, diagnostic and major surgical care, including operating room services; and
(2) maintain, or be under the supervision of, a staff of duly licensed Doctors; and
(3) provide 24 hour nursing care by or under the supervision of a registered nurse (R.N.)

The term "Hospital" does not include:

(1) any institution which is used primarily as a facility for the aged, chronically ill, convalescents, drug addicts, alcoholics, or providing primarily custodial, educational, rest or rehabilitative care or care of Mental or Nervous Disorders; or
(2) any military or veteran's hospital, soldier's home or any hospital operated or contracted for by the Federal Government for the treatment of members or former members of the Armed Forces unless the Insured Person is legally required to pay for services in the absence of this insurance coverage.

Injury:

accidental bodily Injury or injuries sustained by an Insured Person which directly causes the loss, independent of Sickness, bodily infirmity, or any other cause, and which occurs after the Insured Person's coverage has become effective and while the coverage is in force.

In-Network:

use of services of a member of the Preferred Provider Organization (PPO).

Insured Person:

You or a Covered Dependent under this Certificate.

Lifetime Maximum Amount:

all amounts paid by Us will be accumulated from the date of issue toward the Lifetime Maximum Amount. The Lifetime Maximum Amount is the most that We will pay under this Certificate for In-Network and Out-of-Network services for each Insured Person. Any amounts paid by You will not count toward Your Lifetime Maximum Amount. Benefits paid for In-Network services count toward the In-Network Lifetime Maximum Amount only. Benefits paid for Out-of-Network services count toward both the In-Network Lifetime Maximum Amount and the Out-of-Network Lifetime Maximum Amount.

Medical Director:

means Our Medical Director or his/her designee.

Medical Emergency:

an unexpected and unforseen disease, Sickness or Injury which would result in disability or death if not treated immediately.

Medically Necessary:

the treatment, services or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based upon generally accepted current medical practice. It does not include services or supplies which are:

(1) provided solely as a convenience; or
(2) not appropriate to the diagnosis or symptoms; or
(3) part of a plan of treatment that is experimental, unproven or related to research; or
(4) provided mainly for educational purposes.

Medicare:

the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Medicines or Drugs:

medicines or drugs prescribed in writing by a Doctor and available only by written prescription.

Mental or Nervous Disorder:

a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind including but not limited to Attention Deficit Disorder, Bipolar Affective Disorder or Autism.

Non-Participating Provider:

any licensed or certified Physician, referral Physician, health professional, Hospital, Home Health Care Agency, or other licensed or certified entity or person who has not entered into a contract with Us or Our designated Representative to provide health care services to Insured Persons under this Certificate.

Out-of-Network:

use of services of a provider who is not a member of the Preferred Provider Organization (PPO).

Out-of-Pocket Maximums:

the total amount of Deductibles and Coinsurance the Insured must pay in a calendar year. There are separate Out-of-Pocket Maximums which must be satisfied for In-Network and Out-of-Network Services.

The In-Network Out-of-Pocket Maximum can only be satisfied with Deductibles and Coinsurance resulting from Covered Services provided by a Preferred Provider.

The Out-of-Network Out-of-Pocket Maximum can only be satisfied with Deductibles and Coinsurance resulting from Covered Services provided by an Out-of-Network provider.

Cost Sharing arising from your failure to meet the requirements of Prior Authorization and Concurrent Review is **not** accumulated toward satisfaction of the Out-of-Pocket Maximum.

Physician:

a legally qualified licensed practitioner of the healing arts who provides care within the scope of their license. (A member of the Insured Person's immediate family will not be considered a Physician.)

Pre-Existing Condition:

a medical condition, Sickness or Injury not excluded by name or specific description for which:
(1) medical advice, consultation, or treatment was recommended by or received from a Physician within the one year period before the effective date of coverage; or
(2) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the one year period before the effective date of coverage.

Preferred Provider/Participating Provider:

any licensed or certified Physician, referral Physician, health professional, Hospital, Home Health Care Agency, or other licensed or certified entity or person who has entered into a contract with Us or Our designated Representative to provide health care services to Insured Persons under this Certificate.

Preferred Provider Organization (PPO):

a managed health care arrangement in which the Insured Person has access to a network of contracted providers from whom the Insured Person must receive medical services in order to realize the maximum benefits payable under this Certificate.

Primary Care Physician:

a Physician who practices in the medical field of general practice, family practice, pediatrics, obstetrics, or internal medicine, or has been authorized by Us or Our designated Representative to act as a Primary Care Physician.

The practice of obstetrics does not imply coverage for normal pregnancy which may be added by a separate rider.

Prior Authorization:

the procedure whereby We or Our designated Representative determine, based on medically recognized criteria, whether or not an Admission to a Hospital as an inpatient or a plan of treatment as an outpatient is reasonable for the type of services to be received.

Radiation Therapy:

means treatment using cobalt, radium, radioactive isotopes or x-rays administered in a hospital by a licensed radiologist for the purpose of modification or destruction of cancerous tissue. Checkups, physical examinations, treatment planning consultations, diagnostic or laboratory tests are not considered Radiation Therapy.

Regular Charges:

for Preferred Providers, the charges for medical services or supplies which are in an amount determined by agreement between the Preferred Provider and Us. For Non-Preferred Providers, an amount not exceeding the rate regularly charged and received for a given service or supply by the Physicians or other providers of medical services.

Same-Day Surgery Facility:

a licensed or certified public or private medical facility:
(1) with an organized staff of Physicians; and
(2) which is permanently equipped and operated primarily for the purpose of performing surgical procedures.

Such facility must provide continuous Physician services and registered professional nursing services whenever a patient is in the facility.

The term "Same-Day Surgery Facility" will include facilities, operated by a Hospital, which provide scheduled, non-emergency, outpatient surgical care.

The term "Same-Day Surgery Facility" does not include:
(1) Hospital emergency room;
(2) trauma center;
(3) Physician's office;
(4) clinic; or
(5) surgical suite.

Sickness:

Sickness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force.

Skilled Nursing Facility:

a facility which:
(1) is licensed by the State; and
(2) provides skilled nursing care under the supervision of a Physician; and
(3) has 24 hour-a-day nursing services by or under the supervision of a registered nurse (R.N.); and
(4) keeps a daily medical record of each patient.

It does not include a facility or any of its sections which is primarily a place for persons suffering from a Mental or Nervous Disorder, Alcohol or Drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Specialty Care Physician:

a physician other than
(1) a Primary Care Physician;
(2) a Physician whose services are listed under the "Other Services" section; and
(3) a Physician or other professional listed in the "Exclusions and Limitations" section.

You, Your, Yours:

the association member named in the Certificate Schedule whose coverage has become effective and has not terminated.

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COST CONTAINMENT

Prior Authorization Requirement

Prior Authorization is designed to allow the Insured Person to avoid unnecessary confinements for procedures that can reasonably be performed on an outpatient basis. **We require that hospital admissions, inpatient surgical procedures, and outpatient procedures for the procedures and surgeries listed in the attached endorsement (entitled MEDICAL PROCEDURES WHICH REQUIRE PRIOR AUTHORIZATION), receive Our or Our designated Representative's Prior Authorization.** We or Our designated Representative will authorize only those courses of treatment that are the most efficient and cost effective care for an Insured Person's Sickness or Injury. You must request Prior Authorization at least 5 days (or as soon as possible) before the Insured Person's scheduled admission or treatment. However, in the case of maternity (if included by Rider) or Medical Emergency admission, We or Our designated Representative must be notified by the Insured Person's Physician or Hospital within 48 hours of admission (72 hours if a weekend admission) or as soon thereafter as reasonably possible. If the Physician responsible for the treatment is a member of the PPO, he will arrange for Prior Authorization for the Insured Person. If the Physician responsible for the treatment is not a member of the PPO, You have the responsibility to perform the necessary notification. Benefits will be limited to the length of stay approved.

If Prior Authorization is not secured, the Cost Sharing for Covered Services is increased regardless of medical necessity. The Cost Sharing without Prior Authorization is shown in the Certificate Schedule.

Concurrent Review

Concurrent reviews are performed during Hospital confinement to determine continued medical necessity. When the approved length of stay must be exceeded for Medically Necessary reasons, the attending Physician must contact Us or Our designated Respresentative to obtain approval for the additional days. If the attending Physician is not a member of the PPO, You are responsible for contacting Us or Our designated Representative for approval of additional days.

If in the opinion of Our Medical Director, or his designee, extending the length of stay is not Medically Necessary or appropriate for the medical condition, the Cost Sharing for Covered Services is increased.

An alternative facility may provide appropriate, effective and less costly care. The approval for additional days may be limited to the type of facility.

The Cost Sharing for the Length of Stay in excess of the Approved Length of Stay is shown in the Certificate Schedule.

Case Management

Case Management is a method where We or Our designated Representative will review an Insured Person's health problem and develop a plan of care that meets their particular need and is the most cost effective. Case Management authorized by Us or Our designated Representative can provide reimbursement for alternative methods of care, even if the person is not covered for the alternate care or setting. The intent of Case Management is to ensure appropriate, cost effective care by extending extra-contractual benefits for alternative methods of care to persons who require the acute level of care setting. It is not designed to extend extra-contractual benefits for alternative methods of care to persons who do not meet Our standards or for services not authorized by Us or Our designee.

Benefits will be provided for the approved alternative methods of care only when and for so long as is determined that the alternative services are Medically Necessary and cost effective. These benefits will count toward a person's Lifetime Maximum Benefits.

Our decision to implement Case Management will be made following consultation with the affected Insured Person, or his or her legal representative, and the Insured Person's Physician.

If alternative benefits are provided for a person in one instance, it will not obligate Us to provide the same or similar benefits for any person in any other instance; nor will it be construed as a waiver of Our right to administer the Group Policy in strict accordance with its express terms.

Second Physician's Opinions

As part of the Prior Authorization procedures, We or Our designated Representative may require an Insured Person to obtain a second opinion with respect to the procedure in question from a Physician selected by Us. The Insured Person must cooperate in obtaining a second opinion including any examination, testing, x-ray, or diagnostic procedures as are reasonable. There is no Coinsurance for the Physician's evaluation for the second opinion, nor for any tests needed to form the second opinion.

Pre-Admission Testing

As part of the Prior Authorization procedures, We or Our designated Respresentative may require that certain testing be done before admission to a Hospital. There is no Coinsurance for pre-admission testing.

PRIMARY CARE PHYSICIAN

Selection

Each Insured Person may select any Physician at any time. The Insured Person may change physicians at any time and may get treatment from any specialist at any time without being directed by a Primary Care Physician. The benefits will differ on the basis whether the Physician is or is not a member of the PPO.

COVERED SERVICES

This Section describes what is covered when the Insured Person is sick or injured, subject to the Exclusions and Limitations. Your Certificate Schedule shows the Deductibles and Coinsurance, benefit levels and limits. Covered Services must be Medically Necessary and incurred by You or Your Covered Dependents, while insured.

Hospital Inpatient Services

Hospital Inpatient Services

Hospital Inpatient Services are covered as Medically Necessary when admitted to a Hospital. The benefit is subject to a Deductible and Coinsurance, shown in the Certificate Schedule. **Admissions not receiving Prior Authorization and procedures performed beyond the approved length of stay are subject to higher cost sharing as indicated in the Certificate Schedule.**

Hospital Inpatient Services include the use of the operating room; recovery room; anesthesia; surgical dressings; central supplies; casts and splints; Medicines or Drugs; x-ray photographs; laboratory service and oxygen, equipment and services.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use while Hospital Confined are not Covered Services.

Hospital Room and Board

Covered Services include semi-private accommodations, general nursing care furnished by the Hospital, meals, special diets when Medically Necessary, use of operating room and related facilities, intensive care and cardiac unit. The charges for a private room which exceed the charges for a semi-private room are not covered unless a private room is Medically Necessary.

Physician Services

Physician Services While Hospitalized

Covered Services while hospitalized include services by the Physician, surgeon, assistant surgeon, anesthesiologist, and other appropriate medical personnel as Medically Necessary.

Hospital Outpatient Services

Emergency Room Treatment

Covered Services include Emergency Room Treatment provided only for medical emergency conditions requiring immediate medical attention. The Sickness or Injury must be of such gravity that it is not feasible to schedule an appointment. The Emergency Room Coinsurance is shown in the Certificate Schedule. We should be notified within forty-eight (48) hours of any medical emergency requiring admission. Emergency Room Coinsurance is waived when the Insured Person is admitted to the Hospital through the Hospital emergency room.

Outpatient Surgery

Covered Services include Outpatient Surgery. **Prior Authorization must be secured for all services**, unless the Insured Person requires immediate medical attention.

Chemotherapy and Radiation Therapy

Covered Services include Chemotherapy and Radiation Therapy administered in a Hospital as Medically Necessary for the treatment of cancer. Hospitalized means admitted to a Hospital, on either an inpatient or outpatient basis. Benefits are subject to the Coinsurance listed on the Certificate Schedule under Hospital Outpatient Services.

Treatment that is provided in a physician's office is not a Covered Service under this Certificate. Coverage may be provided by a separate rider.

Home Health Services

Covered Services include Home Health Services as Medically Necessary, subject to the Coinsurance listed in the Certificate Schedule. The dollar Coinsurance listed is the amount per visit. Up to 4 consecutive hours in a 24-hour period is considered one visit. A visit of 4 hours or more is considered one visit for every 4 hours or part thereof.

Covered Services include medical care provided by or under the supervision of a registered nurse, including therapeutic injections, medical appliances and equipment, and laboratory services.

The attending physician must certify that the Home Health Services could not be provided at the physician's office and that in the absence of such services, the Insured Person would have to be confined in a Hospital or Skilled Nursing Facility. Home Health Services are subject to Concurrent Review and Case Management. Concurrent reviews are performed by Us or our designated Representative during the planned program of observation and treatment. When the planned program is submitted or altered, the attending physician must contact Us or our designated Representative. If the attending physician is not a member of the PPO, You are responsible for contacting us.

Dialysis

Covered Services include Kidney Dialysis as Medically Necessary.

Other Services

Medically Necessary Ambulance Transport

Covered Services include Ambulance Transport as Medically Necessary to or from:

(a) a Hospital; or
(b) a Skilled Nursing Care Facility.

Medical and Surgical Supplies

Covered Services include Medical and Surgical Supplies for use while confined in a Hospital, Same Day Surgery Facility, or Skilled Nursing Facility as Medically Necessary.

Temporomandibular Joint Dysfunction Treatment

Covered Services include Physician and Dentist services as Medically Necessary as determined by the Medical Director. Physician office visits are covered only if Physician Services Rider is attached. Services are subject to the Coinsurance per visit listed in the Certificate Schedule. Surgical correction is subject to the Inpatient Hospital, or Outpatient Hospital Coinsurance listed in the Certificate Schedule.

Additional Covered Services

Covered Services at a Skilled Nursing Care Facility

Charges for a Skilled Nursing Care Facility stay will be Covered Services. The benefit is subject to a Deductible and Coinsurance, shown in the Certificate Schedule. **Benefits are provided only to the extent authorized under the Concurrent Review and Case Management Provisions of this Certificate.**

Hospice Care:

Charges for services and supplies provided by a Hospice or Hospice Team under a Hospice Care Program, are Covered Services if:
(1) recommended by the Insured Person's Physician;
(2) the Insured Person's Physician certifies that the Insured Person is not expected to live more than six months; and
(3) the services and supplies are ordered by the Physician directing the Hospice Care Program.

The benefit is subject to a Deductible and Coinsurance. For Inpatient Hospice, the Deductible and Coinsurance listed for Inpatient Hospital applies. For outpatient Hospice, the Deductible and Coinsurance listed for Home Health applies.

Benefits are provided only to the extent authorized under the Concurrent Review and Case Management Provisions of this Certificate.

Covered Services for Complications of Pregnancy

Covered Services associated with Complications of Pregnancy will be considered the same as a Sickness. Delivery by Cesarean Section is not a Complication of Pregnancy unless it is involuntary and performed to save the life of the mother or unborn child.

Covered Services for Dental Injury

Covered Services include Regular Charges for dental care, treatment, or surgery due to Injury to sound natural teeth. The charges must be incurred within one year from the date of Injury and while this Certificate is in force.

EXCLUSIONS AND LIMITATIONS

General

Except where prohibited by law, We will not provide benefits for any loss resulting from:
(a) services of private or special duty nurses other than when Medically Necessary in a Hospital;
(b) services of physiologists, social workers, naturopaths, rolfers, and acupuncturists are not covered;
(c) care in a nursing home, custodial institution or domiciliary care or rest cures;
(d) preparation and presentation of medical reports for appearance at trials or hearings. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded. Immunizations required for the sole purpose of travel outside of the U.S.A.;
(e) payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
(f) all experimental medical, surgical or other health care procedures, treatments, products or services;
(g) personal comfort items, such as television, telephone, lotions, shampoos, etc.;
(h) provision or payment of services when not rendered in accord with Our policies or procedures;

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(i) any care deemed not Medically Necessary by the Medical Director, and any Hospital or medical care services not specifically provided for in this Certificate;
(j) mental health care, alcoholism, drug abuse, and addiction services, unless added by endorsement;
(k) prescription Drug Benefits except as provided under a Supplemental Prescription Drug Rider;
(l) any act of war, declared or undeclared;
(m) suicide, attempted suicide, or any intentionally self-inflicted Injury, while sane or insane;
(n) any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act; or similar act or law, unless the Insured Person is self-employed;
(o) Cosmetic Surgery, except reconstructive surgery, incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part and reconstructive surgery due to a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
(p) any drug, treatment or procedure that either promotes or prevents conception or prevents childbirth, including but not limited to: 1. artificial insemination; 2. in-vitro fertilization or other treatment for infertility; 3. treatment for impotency; 4. sterilization or reversal of sterilization; or 5. abortion (unless the life of the mother would be endangered if the fetus were carried to term);
(q) radial keratotomy or any eye surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
(r) charges for blood, plasma, or blood derivatives;
(s) occupational therapy or occupational rehabilitation;
(t) weight loss or modification, or complications arising therefrom, or procedures resulting therefrom, or for surgical treatment of obesity, including wiring of the teeth and all forms of bypass surgery performed for the purpose of weight loss or modification;
(u) breast reduction or augmentation;
(v) modification of the physical body in order to improve the psychological, mental, or emotional well-being of the Insured Person, such as sex-change surgery;
(w) marriage, family or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
(x) hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 30 days after the Insured Person becomes covered under this Certificate;
(y) while engaging in an illegal occupation or illegal activity;
(z) dental care, except as provided herein;
(aa) charges for which benefits are not specifically provided herein;
(bb) while being intoxicated, under the influence of intoxicants or under the influence of any narcotic, unless taken as prescribed by a Doctor;
(cc) vision and hearing exams to determine the need for correction;
(dd) well child care, unless added by a rider;
(ee) physical examinations, unless added by a rider;
(ff) immunizations and injections, unless added by rider;
(gg) diagnostic services, including radiology, pathology, laboratory tests, electrocardiograms, electroencephalograms, MRI, CT Scans, unless added by rider. This includes diagnostic services performed in support of outpatient surgery, outpatient radiation or chemotherapy, and procedures performed in a physician's office;
(hh) physician office visits, including Chemotherapy and Radiation Therapy performed in a physician's office, unless added by rider;
(ii) Chiropractic Services;
(jj) Podiatry Services in the absence of severe systemic disease. Among excluded procedures are the removal of warts, corns, calluses, the cutting and trimmng of toenails, care for flat feet, fallen arches or chronic foot strain.

Pregnancy

Coverage for a normal pregnancy is not provided. Childbirth benefits will be provided by a supplemental rider, if attached. Complications of Pregnancy will be covered as a Sickness if the Insured Person's coverage is in force at the time of loss. It may be necessary for a Physician to furnish medical evidence confirming the inception date of any pregnancy.

Pre-Existing Condition

We will not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred one year after the effective date of coverage for an Insured Person.

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Pre-Existing Conditions are any Sickness or Injury not specifically excluded by name or description for which medical advice, consultation or treatment was recommended or received from a physician within the one year period prior to the effective date of coverage; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the one year period before the effective date of coverage.

Rehabilitative Services

We will not provide benefits for any service or supply provided to an Insured Person as an outpatient at a Hospital or other facility where the admission or treatment is primarily to provide Rehabilitation Services. Rehabilitation Services include physical, occupational, and speech therapy. Coverage for these services may be added by a rider.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your Enrollment Application based upon the information You provided therein, coverage for You and those dependents listed in the Enrollment Application and accepted by Us will begin on the Certificate Date shown in the Certificate Schedule.

Newborn Children

If You have one or more Eligible Dependents covered under the Group Policy, Your newborn children will be provided coverage after the Certificate Date from the moment of birth for 31 days. To continue coverage beyond 31 days, You must send written notice directing Us to add the newborn child. This notice must be received by Us within 31 days of the newborn child's birth and must be accompanied by any required additional premium.

If no Eligible Dependents are covered under this plan at the time a child is born to the Insured, such newborn child will not be a Covered Dependent from the time of birth. Such child may only be added in accordance with the "Additional Dependents" provision below.

Additional Dependents

You may add Eligible Dependents by providing evidence of eligibility and insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent will be shown by endorsement and the date of the endorsement will be the effective date of coverage for the new Eligible Dependent.

PREMIUMS

Due Date

Premiums are payable to Us at Our office at North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Any indebtedness of the Insured Person to Us arising out of prior claims may be deducted in any settlement under the Group Policy.

Grace Period

A grace period of 31 days, measured from the premium due date, will be allowed for payment of all premiums due, other than the first. During this time, the coverage will remain in force, unless We receive written notice that the coverage is to be terminated.

Premium Changes

We reserve the right to change the table of premiums, on a class basis, becoming due under the Group Policy at any time and from time to time; provided, We have given the Group Policyholder written notice of at least 31 days prior to the effective date of the new rates.

TERMINATION OF COVERAGE

Your coverage and that of Your Covered Dependent(s) will terminate and no benefits will be payable on or after: (1) the date the Group Policy terminates; (2) upon nonpayment of premium, subject to the grace period; or (3) the date You cease to be a member in good standing of the association or group covered under the Group Policy.

Coverage on any Insured Person will terminate on the premium due date next following the date the person qualifies for Medicare at any age or reaching age 65. If an Insured Person who is age 64 but not yet age 65 pays an annual premium that would otherwise pay for coverage beyond age 65, the Insured shall be entitled to an appropriate refund of unearned premium when the coverage terminates upon the Insured's attainment of age 65.

You may terminate Your coverage and that of Your Covered Dependent(s) by providing Us with written notice of cancellation. Your coverage and/or that of Your Covered Dependent(s) will be terminated:
(1) on the next premium due date, if Your mode of payment is monthly; or,
(2) on the latter of: (a) the date We receive Your written notice of cancellation; or (b) Your requested termination date, if Your mode of payment is other than monthly.

If a Covered Dependent child who has been continued beyond the limiting age as a full-time student ceases to be a full-time student, our liability under the Group Policy will be limited to a refund of premium from the date the child ceased to be a full-time student.

The attainment of the Limiting Age for a Covered Dependent will not cause coverage to terminate while that person is and continues to be both: (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (b) Chiefly Dependent on You for support and maintenance.

"Chiefly Dependent" means the Covered Dependent receives the majority of his/her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person at least 31 days prior to the date upon which the dependent would otherwise reach the Limiting Age and, thereafter, We may require such proof not more frequently than annually. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Group Policy

We or the Group Policyholder may terminate the Group Policy, provided written notice is given to the other party at least 31 days prior to the date of termination.

Total Disability

If an Insured Person is Totally Disabled at the time the Group Policy terminates, benefits will be payable subject to the regular benefit limits of the Group Policy, for Covered Expenses incurred due to the Sickness or Injury which caused such Total Disability. This extension of benefits will cease on the earliest of: the date on which the Total Disability ceases; or the end of the 90 day period immediately following the date on which their insurance terminated.

For the purpose of this section, the terms "Total Disability" and "Totally Disabled" mean: (a) with respect to You, Your complete inability to perform all of the substantial and material duties and functions of Your occupation or any other gainful occupation in which You earn substantially the same compensation earned prior to disability; and (b) with respect to Your Covered Dependents, confinement as a bed patient in a Hospital.

Conversion on Termination

If Your insurance terminates because of eligibility for coverage prior to Your becoming eligible for Medicare benefits, You will be entitled to have issued to You, without evidence of insurability, a policy of health insurance, either individual or family, whichever is appropriate, provided application for the policy is made and the first premium is paid to Us within 31 days after such termination.

The following will also apply:
(1) The coverage under the policy shall be in an amount equal to or, at Our option, less than the amount of health insurance which ceases because of such termination.
(2) The premium on the policy shall be the customary rate applicable to similar policies issued by Us, to the class of risk to which You belong and Your age on the effective date of the policy.
(3) The policy will not result in overinsurance on the basis of Our underwriting standards at the time of issue.
(4) The policy may exclude any condition excluded by the prior policy.

FAMILY SECURITY BENEFIT

Beginning with the next premium due date following Our receipt of due proof of the Insured's death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period no increase in benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will apply. Upon expiration of the waiver period, Your Covered Dependent spouse may continue coverage by making required premium payments and by becoming a member of the association covered under the Group Policy.

COORDINATION OF BENEFITS

All of the benefits provided under the Group Policy are subject to this provision. However, Coordination of Benefits (COB) may not be applied to claims less than fifty dollars ($50.00). If additional liability is incurred to raise the small claim above fifty dollars ($50.00), the entire liability may be included in the COB computation.

"Plan" means any plan providing benefits or services for or by a reason of hospital, medical, or dental care or treatment, which benefits or services are provided by:
(a) group or blanket insurance coverage;
(b) group Blue Cross, Blue Shield or other prepayment coverage provided on a group basis;
(c) any coverage under labor-management trustee plans; union welfare plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group; and
(d) any coverage under governmental programs, except Medicaid, and any coverage required or provided by any statute.

The term "plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"This Plan" refers to provisions of the Group Policy which are subject to this section.

"Allowable Expense" will be any necessary, regular, and customary expense, all or part of which is covered by at least one of the plans covering the Insured Person. Allowable Expenses to a "secondary" plan will include the value or amount of any deductible amount or co-insurance percentage or amount of otherwise Allowable Expenses which is not paid by the "primary" or first paying plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

"Claim Determination Period" is a calendar year or portion thereof during which the Insured Person has been covered under This Plan.

Determination of benefits payable under This Plan and all other applicable plans will be controlled by this provision, if without this provision the sum of the benefits payable under:
(1) This Plan; and
(2) all other applicable plans,
would exceed the Allowable Expense.

If the sum of (1) and (2) above does exceed the total Allowable Expense, benefits payable under This Plan will be reduced by the amount of benefits payable under all other plans.

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Benefits of any other plans which contain a COB provision will be ignored when computing the benefits of This Plan if:
(1) the other plan's COB provision states that the benefits will be determined after This Plan computes its benefits; and
(2) the rules set forth below would require This Plan to compute its benefits first.

The rules that set the order of benefit determination are:
(1) a plan that covers the Insured Person other than as a dependent will compute benefits before a plan that covers the Insured Person as a Dependent; and
(2) when a dependent is a child covered under separate plans of each parent, the plan covering the parent whose date of birth (month and day) precedes the other in the calendar year shall be primary; except:
    (a) where both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or
    (b) where the parents are separated or divorced and the parent with custody of the child has not remarried, then the plan covering the parent with custody shall be primary; or
    (c) where the parents are divorced and the parent with custody of the child has remarried; then: (i) the plan covering the parent with custody shall be primary, or (ii) the plan covering the step-parent of the child shall be primary to that of the parent without custody; or
    (d) notwithstanding subparagraphs (a), (b), and (c) above, where the parents are divorced or separated and there is a court decree establishing the financial responsibility of medical or other health care expenses with respect to the child on one parent, then the plan covering the parent with the financial responsibility shall be primary; and
(3) If benefit determination order is not established above, the primary plan is the plan which has been in effect the longest except:
    (a) if plan benefits of the Insured Person are based on a laid-off, or retired employee or a dependent of either, then that plan will be secondary to the other plan's benefits. If neither plan has a provision for a laid-off, or a retired employee or a dependent of either and each plan determines benefits after the other, then this subparagraph (a) is not applicable.

We reserve the right to release or obtain information that We deem necessary, about any person to or from:
(1) any other insurance company; or
(2) any organization or person.

At Our request, the Insured Person shall furnish Us with any information needed to determine payment of benefits under this COB provision.

Facility of Payment

Whenever benefits which should have been paid under This Plan are paid under any other Plan, We shall have the right to pay to the organization that made the payments any amount that We feel will satisfy this provision. Amounts so paid will be deemed benefits paid under This Plan and We will be fully discharged from liability under This Plan.

Right of Recovery

If We, at any time, pay the total Allowable Expense and that amount exceeds the payment required to satisfy the intent of this provision, We will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as We shall determine: any persons to or for or with respect to whom such payments were made; any other insurance companies; any other organization.

Time Limit for Payment

Payment of benefits must be made within thirty (30) calendar days after submittal of a proof of loss, unless We provide the claimant a clear and concise statement of a valid reason for further delay which is in no way connected with or caused by the existence of this COB provision nor otherwise attributable to Us.

GENERAL PROVISIONS

Entire Contract

The Entire Contract will consist of: (a) the Group Policy; (b) the Application of the Group Policyholder, which will be attached to the Group Policy; and (c) any Enrollment Applications for the proposed insured individuals; and (d) any riders or endorsements attached.

All statements made by the Group Policyholder or by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Group Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Group Policy. Any change in the Group Policy will be made by amendment approved by the Group Policyholder and signed by Us. Such amendment will not require the consent of any Insured Person.

Certificate

This Certificate summarizes Your rights and benefits under the Group Policy and does not constitute a part of the Group Policy and does not change any of the conditions and provisions of the Group Policy. A copy of Your Enrollment Application is attached to this Certificate.

Assignment of Claim Payments

Payment for services provided by the Preferred Provider is automatically assigned to the provider. The Preferred Provider is responsible for filing the claim and We will make payments directly to the provider for benefits in excess of Your Copayment.

Notice of Claim

Written notice of claim must be given to Us as soon as possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to Us at North Richland Hills, Texas within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all benefits due under the Group Policy within 25 working days after receipt of due proof of loss. Should there be a delay in such payment, interest shall be payable on the claim commencing on the 26th day at a rate of 1.5% per month thereof until the claim is paid. If the Company does not pay when due, the Insured may bring action to recover such benefits and any other damages.

All Out-of-Network benefits are payable to You. If any such benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse; mother; father; child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment. You may assign all or a portion of any payable benefit.

Physical Examination

We will, at Our own expense, have the right and opportunity to examine the Insured Person whose Injury or Sickness is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

DUPLICATE

Legal Action

No action at law or in equity will be brought to recover on the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy, nor will any action be brought after expiration of three years after the time written proof of loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due Us because of past under-payments, will be made so that We receive the premiums due at the correct age.

Incontestability

A. After two years from the effective date of an Insured Person's coverage, no misstatements, except fraudulent misstatements, made in the Enrollment Application will be used to void the coverage, or deny a claim unless the loss was incurred during the first two years following such Insured Person's effective date of coverage.
B. No claim for a loss incurred one year after the effective date of an Insured Person's coverage will be reduced or denied as a Pre-Existing Condition.

Conformity

Any provision of this Certificate which, on its effective date, is in conflict with the statutes of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Subrogation

You agree that We shall be subrogated to Your right to damages, if You are made whole, to the extent of the benefits provided by the policy, for Injury or Sickness that a third party is liable for or causes.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a ~~claim~~ against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

Right of Reimbursement

You may receive benefits under the Policy, and may also recover losses from another source, including Workers' Compensation, uninsured, underinsured, no-fault or personal injury protection coverages. The recovery may be in the form of a settlement, judgement, or other payment.

You must reimburse Us from these recoveries in an amount up to the benefits paid by Us under the Policy. We have an automatic lien on any recovery.

Assignment of Recovery Rights

This Certificate contains an exclusion for Sickness or Bodily Injury for which there is Medical Payment/Expense coverage provided or payable under any automobile, homeowner's, premises or other similar coverage.

If Your claim against the other insurer is denied or partially paid, We will process Your claim according to the terms and conditions of this Certificate. If payment is made by Us on Your behalf, You agree to assign to Us any right You have against the other insurer for medical expenses We pay.

TI000021

ACCIDENT EXPENSE BENEFIT RIDER

This rider is made a part of the Group Policy or Certificate to which it is attached. The rider is subject to all provisions of the Group Policy which are not in conflict with the provisions of this rider.

BENEFITS

We will pay the actual medical expense incurred by an Insured Person for the Medically Necessary treatment of an Injury. This benefit will be payable subject to the following conditions:

a) Initial treatment by a Doctor must begin within forty-eight (48) hours of the Injury; and

b) Any treatment of the injury, beyond the initial treatment, must be received within thirty (30) days of the Injury.

The maximum benefit payable for any one Injury will be the amount listed in the Certificate Schedule.

Manipulation of the spine or reduction of a spinal subluxation due to accidental Injuries covered under this rider will be limited to one such procedure during each 90 day period.

The benefits provided by this rider are in addition to the benefits, if any, provided by the Group Policy and are not subject to the Certificate deductible, if any. However, the total benefits paid under the Group Policy and this rider will not be greater than the actual expense incurred.

We will provide this benefit in consideration of the payment of the premium for this rider.

PFL LIFE INSURANCE COMPANY

Craig D. Vermie
SECRETARY

William L Busbee
PRESIDENT

DUPLICATE

TI000022

GOP 2 487 Rev. 10-91

OUTPATIENT TESTING AND THERAPY BENEFIT RIDER

In consideration of the payment of the required premium, this rider is made a part of the Group Policy and Certificate to which it is attached. The rider is subject to all of the provisions of the Group Policy which are not in conflict with the provisions of this rider.

COVERED SERVICES

This Section describes what is covered when the Insured Person is sick or injured, subject to the Exclusions and Limitations. Your Certificate Schedule shows Deductibles and Coinsurance, benefit levels and limits under this rider. All benefits paid under this rider will be applied to the Maximum Lifetime Benefit amounts listed in the Certificate Schedule. We will pay the Medically Necessary Covered Services provided in Hospital emergency rooms and out-patient facilities, Same Day Surgery Facilities, clinics, and Doctors' offices, if such services are related to and necessary for the diagnosis or treatment of a Sickness or Injury. Covered Services related to a normal pregnancy are excluded, unless a maternity benefit rider is attached.

Diagnostic Services

Covered Services, as Medically Necessary, shall include, but will not be limited to:

Radiology (x-ray)
Pathology
CAT Scans
Magnetic Resonance Imaging
Nerve Conduction Study
Sonogram
Ultrasound
Electrocardiogram
Electroencephalogram
Angiogram
Audiology evaluation including air/bone conduction studies and audiograms
Laboratory tests
Electromyogram
Mammogram
Upper/Lower G.I. Series
Myelogram
Cytologic studies
Blood or serum analysis
Mycrobiological blood assays
Stress tests assays
Pyelogram

Durable Medical Equipment and Prosthetics

Covered Services include Durable Medical Equipment and Prosthetics as Medically Necessary, subject to the Coinsurance listed in the Certificate Schedule.

We will cover the cost of Durable Medical Equipment subject to the following:

- Durable Medical Equipment will not, in whole or in part, serve as a comfort or convenience item for the Covered Person.
- Only the cost of the most cost effective Durable Medical Equipment will be covered. Cost effectiveness will be determined by Us or Our Representative and will be based on the lowest priced Durable Medical Equipment available which can accomodate the medical condition.
- Repair of Durable Medical Equipment is not a Covered Service unless needed due to change or growth in the physical body and then only if the equipment is purchased.
- At our option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase price will be covered.

We will cover prosthetic devices if Medically Necessary. However, repair or replacement will be covered only if it is determined Medically Necessary due to growth or physical change in the body.

Outpatient Rehabilitation

Outpatient Rehabilitation Services include physical, occupational, and speech therapy as Medically Necessary. Coverage for these services are limited to a maximum of sixty (60) days per Insured Person per Calendar Year.

EXCLUSIONS AND LIMITATIONS

No benefits will be payable under this rider for: checkups; physical examinations; treatment planning consultations; Doctors office visit charges; spinal manipulations; prescription drugs and medicines; radiation or chemotherapy for the purpose of modification or destruction of cancerous tissue, or, any tests, procedures or services related to pregnancy or childbirth unless Medically Necessary due to Complications of Pregnancy, as defined in your Certificate. In addition, benefits for physical, occupational, and speech therapy will only be payable in connection with the same Sickness or Injury for which the Insured Person was Hospital Confined or in connection with surgical care. No benefits will be payable for physical, occupational, and speech therapy which: a. commences more than six months after discharge from a Hospital or the date surgical care was rendered; or b. which extends beyond 365 days from the date of discharge from a Hospital or the date surgical care was rendered.

When services covered under this rider are also covered under the Group Policy to which this rider is attached, benefits will be payable under this rider in lieu of the Group Policy. Benefits payable under this rider will be applied to satisfy the Cash Deductible Amount, if any, shown in the Certificate Schedule.

If an Insured Person has coverage in force under another one of our riders, and services covered under this rider are also covered under the other rider, after satisfaction of the Outpatient Testing and Therapy Benefit Rider Deductible, benefits will be payable for such services in excess of those paid under the other rider, not to exceed a combined benefit, including the amounts used to satisfy the deductible, of 100% of the Covered Expenses incurred.

PFL LIFE INSURANCE COMPANY

Craig S. Vernon
SECRETARY

William L Busler
PRESIDENT

TI000024

Outpatient Radiation Therapy and Chemotherapy Rider For Cancer Treatment

This rider is made part of the Group Policy or Certificate to which it is attached. The rider is subject to all of the provisions of the Group Policy which are not in conflict with the provisions of this rider.

DEFINITIONS

Cancer means a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells which expands locally by invasion or systemically by metastasis (for example carcinoma or sarcoma), leukemia or Hodgkin's Disease. Conditions which are considered precancerous or potentially cancerous (for example leukoplakia, carcinoid, hyperplasia, polycythemia or benign melanoma) do not qualify as cancer in this rider.

Positive Diagnosis of Cancer means a pathological diagnosis made by a doctor (or physician) certified by the American Board of Pathology to practice Pathologic Anatomy or a certified Osteopathic Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system. In establishing positive diagnosis, the judgement of the doctor (or physician) shall be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture of the suspect tissue, tumor or specimen. Clinical diagnosis will be accepted as positive diagnosis when a pathological diagnosis cannot be made provided such medical evidence substantially documents the diagnosis of cancer.

Outpatient Hospital Stay is a stay for which no charge is made for room and board.

Radiation Therapy means treatment using cobalt, radium, radioactive isotopes or x-rays administered in a hospital by a licensed radiologist for the purpose of modification or destruction of cancerous tissue.

Chemotherapy means treatment using chemical substances, including chemicals used in hormonal therapy or immunotherapy, administered in a hospital by a doctor (or physician) or other medical professional qualified and authorized to administer such treatment for the purpose of modification or destruction of cancerous tissue.

Checkups, physical examinations, treatment planning consultations diagnostic or laboratory tests do not qualify as Radiation Therapy or Chemotherapy in this rider.

TI000025

DUPLICATE

BENEFITS

Once a positive diagnosis of cancer is made, we will pay the actual expense incurred by an Insured Person during an Outpatient Hospital Stay for the treatment of Cancer by Radiation Therapy or Chemotherapy. The maximum benefit payable per Insured Person during any one 24 hour period is $1,000. The maximum lifetime benefit per Insured Person is $100,000. The positive diagnosis of cancer and the subsequent treatment must occur while the Insured Person is covered under this rider in order for the charges to be covered.

Benefit payments made under this rider are not subject to the cash deductible in the Group Policy or Certificate to which it is attached.

If the Group Policy or Certificate to which this rider is attached provides outpatient hospital benefits for Radiation Therapy or Chemotherapy then the benefits in this rider will be paid in lieu of those benefits when they are incurred for the treatment of cancer during an Outpatient Hospital Stay.

We will provide these benefits in consideration for the payment of the premium for this rider.

PFL LIFE INSURANCE COMPANY

Craig D. Vermie
SECRETARY

William L Busbee
PRESIDENT

PFL LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Cedar Rapids, Iowa
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service 1-800-527-5504

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Policy or Certificate to which it is attached. It is subject to all the provisions of the Policy which are not inconsistent with this endorsement.

To comply with Federal law, Public Law No. 104-191, Your Policy or Certificate is revised as follows:

1. The following provisions are hereby added:

   GUARANTEED RENEWABLE: This Policy or Certificate is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the Termination of Coverage section. The Company reserves the right to change the applicable table of premium rates on a class basis. On each anniversary of the Policy or Certificate Date, the premium for the Policy or Certificate may change in amount by reason of an increase in the age of an Insured Person.

   COVERAGE AFTER AGE 65 OR EARLIER MEDICARE ELIGIBILITY: when an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the benefits of this Policy or Certificate and its attachments, if any, are payable only to the extent that Covered Expenses, Covered Medical Expenses or Covered Charges (as defined in Your Policy or Certificate) are not paid by Medicare. The benefits will also be subject to any other exclusions or limitations set forth in the Policy or Certificate.

2. The provision entitled "TERMINATION OF COVERAGE" is amended as follows:

   A. By removing all reference to termination of coverage due to qualification for Medicare or upon reaching age 65; and

   B. By adding the following:

      We will renew this Policy or Certificate each time We receive the correct premium before the end of the Grace Period. We may refuse to renew this Policy or Certificate on any renewal premium due date under any of the following conditions:

      1. Nonpayment of premium, subject to the Grace Period.
      2. Fraud or misrepresentation. If We refuse to renew the Policy or Certificate for such reason, You will be given 30 days notice prior to the effective date of such nonrenewal.
      3. We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status.
      4. We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued.
      5. You terminate Your membership in the Association to which the Group Policy is issued, if applicable.

If in the future, Public Law 104-191 is amended to allow termination of coverage due to eligibility for Medicare, the Company retains the right to take such action.

This Amendatory Endorsement is effective on the later of July 1, 1997 or the effective date of the Policy or Certificate.

In Witness Whereof, the Insurance Company has caused this Amendment to be signed by its President and Secretary.

Craig D. Vermilion
SECRETARY

William L Busbee
PRESIDENT

TI000028

Application to:

PFL LIFE INSURANCE COMPANY

BAPP

FOR HOME OFFICE USE ONLY
Number

Special Request

Life Insurance

PLAN OF INSURANCE Term
PREMIUM AMOUNT
FACE AMT./SPEC AMT.
☒ Level 1 ☐ Level 2
Soc. Security # (Applicant) 418 02 2367

BENEFITS
☐ ADD ☐ WP
☐ _____ ☐ _____

DIVIDEND OPTION
☐ Accumulate at Interest (Automatic Option)
☐ Paid in Cash
☐ Paid up Additions

OWNERSHIP (Life Insurance Only)
(COMPLETE ONLY IF OTHER THAN PRIMARY APPLICANT)
A. OWNERS NAME
B. ADDRESS
C. CITY, STATE, ZIP
D. OWNER'S SOCIAL SECURITY NO.
E. OWNER'S DATE OF BIRTH MO____ DAY____ YR____
AUTOMATIC PREMIUM LOAN (if available) ☐ YES ☐ NO

Health Insurance

PMH
Deductible
☐ $ 250
☐ $ 500
☐ $ 750
☐ $ 1,000
☐ $ 1,250
☐ $ 1,500
☐ $ 1,750
☐ $ 2,000
☐ $ 2,500
☐ $ 5,000

Health Insurance Applied For:

GHP6 MAX BENEFIT
☐ $500,000
Ded. $ _____

DAILY BENEFIT
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $____
Ded. $ _____
☐ GHP7 ☐ GHP5

GHP8
☐ 100%
☐ 80/20
☐ 50/50
☐ _____
Ded. ☐ $600
☐ $1,200
☐ $2,400
☐ $____

☒ PPO ☐ EPO
PPO Copay Options
☒ 10 ☒ A
☐ 15 ☐ B
☐ 20 ☐ C
☐ 25 ☐ D
☒ Rx
☐ Vision
☐ Other

Social Security # (Applicant) 418 02 2367

OTHER COVERAGE (if any) Amount / Add'l Premium

	Amount	Add'l Premium
☐ Accident Benefit	$	$
☐ Childbirth Benefit	$	$
☑ OP Chemo. Benefit		$
☐ Ret. of Prem. Ben.		$
☑ Test./Therapy Ben.		$
☐ Outpatient Care Opt.(Ded)	$	$
☐ Cat. Expense Ben. (Ded.)	$	$
☐ Accident Waiver Ben.		$
☐ Double Misc. Ben.	$	$
☐ Triple Misc. Ben.	$	$
☐ Double Surg. Ben.	$	$
☐ Triple Surg. Ben.	$	$
☐ Life Ins. Benefit Rider	$	$
☐ Prescription Drug Rider		$
☐ Other	$	$
Total Additional Premium		$

Dental Insurance

☒ YES ☐ NO
If applying for Dental Insurance, is any Proposed Insured person in the full-time service in the armed forces (other than for training for a period not to exceed 60 days)?
☐ YES ☐ NO
If yes, list name(s)

Soc. Security # (Applicant) 418 02 2367

Disability Income Insurance

☐ Disability Income
Amount $ _____
Elimination Period _____
Benefit Period _____
Occ Class _____
Soc. Security # (Applicant)

Other Coverage (if any) / Add'l. Prem.

☐ AD & D		$
☐ Return of Premium		$
☐ Hospital Conf.		$
☐ Business Overhead		$
Mo. Max.	$	
Elim. Prd.	$	
☐ Other		$
Total Addt'l. Premium		$

Accident Insurance

DAILY BENEFIT-GACC7
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $ _____
Ded. $ _____

GACC8
☐ 100%
☐ 80/20
☐ 50/50
☐ _____
Ded. ☐ $600
☐ $ _____
☐ $2,400
☐ $ _____

Social Security # (Applicant)

OTHER COVERAGE (if any)

	Amount	Addt'l Premium
☐ Accident Benefit	$	$
☐ Double Misc. Ben.	$	$
☐ Triple Misc. Ben.	$	$
☐ Double Surg. Ben.	$	$
☐ Triple Surg. Ben.	$	$
☐ Spc. Dis. & Emerg. Med. Care Benefit	$	$
☐ Acc. & Spc. Dis. OP Therapy Benefit	$	$
☐ Other	$	$
Total Additional Premium	$	$

BENE-FICIARY
PRIMARY Jerry M. Tillerson
RELATIONSHIP Father
SOCIAL SECURITY # 416 48 8965

CONTINGENT Carol J. Owens
RELATIONSHIP Mother
SOCIAL SECURITY #

6900-AG (794)

TI000029

SECTION A — **COMPLETE THIS SECTION FOR ALL APPLICATIONS**

1. *PRINT* name of applicant and each member of the family (including wife's maiden name)	Relationship	State of Birth	Sex	Date of Birth Mo.	Day	Yr.	Present Age	Height	Weight Now	1 Yr. Ago	Premium
(1) Troy E. Tillerson	Applicant	AL	M	3	22	64	32	6'	235	235	$
(2)	Spouse										
(3)											
(4)											
(5)											
(6)											

Pay mode: Monthly ☒ Quarterly ☐ Semi-Annually ☐ Annual ☐ Total Premium ______

Insurance applied for: Life = L Health = H Dental = Den Disability Income = Dis Accident = A Rx Drug = Rx Vision = V
Member # (1) Applicant H, A, Rx, D (2) Spouse ______ (3) ______ (4) ______ (5) ______ (6) ______

2. Addresses: Number and Street or R.F.D. City State Zip Telephone
☐ a. Permanent U.S. Residence 459 S. [illegible] Hill Rd Dale [illegible] [illegible]
b. Business Name Alabama Home Inspection
☐ c. Business Address Same

3. a. Primary Occupation: (Member 01) Home Inspector
b. Duties (describe in detail): Inspects Home

c. List any other occupations, second jobs or part-time jobs and your duties:

SECTION B — **COMPLETE THIS SECTION FOR HEALTH, LIFE, DISABILITY INCOME AND ACCIDENT**

	Yes	No
4. I am a member of the National Association for the Self Employed	☒	☐
5. Are any family members covered under Medicaid or Medicare?	☐	☒

Name(s) ______

6. Has any person proposed for insurance:
a. Ever had an application or reinstatement for life, disability income or accident and sickness insurance declined, postponed, rated up, modified, or terminated? — Yes ☐ No ☒
b. Had a drivers license suspended or revoked in the last two years? — Yes ☐ No ☒
Give details if any question is answered "Yes": ______

7. Are all children or stepchildren of the Applicant proposed for insurance by this Application, currently unmarried and under the age of nineteen (19) years and residing at the Applicant's principal place of residence; or under the age of twenty-four (24) years and enrolled as a full-time student at an accredited college or university? — ☒
If answer is "No," give name(s) and reason:

8. During the past two years, has any person proposed for insurance: Flown in any aircraft other than as a passenger, engaged in any racing, parachuting, scuba diving activities, or other hazardous avocations or does he/she intend to do so in the next 12 months? — Yes ☒ No ☐
If "Yes," give details: Scuba Diving - for 9yrs Stays above [illegible]

SECTION C — **COMPLETE THIS SECTION FOR HEALTH, LIFE AND DISABILITY INCOME**

9. Family Physician/Physician who would have medical records.
a. For Applicant: Name Dr. Mark Hayden Address 26297 [illegible]
City Wetumpka State AL Zip 36092 Telephone No: ( ) [illegible]
Date last seen 1996 Reason Cold
b. For Spouse: Name ______ Address ______
City ______ State ______ Zip ______ Telephone No: ( ) ______
Date last seen ______ Reason ______
c. For Children: Name ______ Address ______
City ______ State ______ Zip ______ Telephone No: ( ) ______
Date last seen ______ Reason ______

TI000030

6900-AG (7/94)

SECTION C CONT'D. COMPLETE THIS SECTION FOR HEALTH, LIFE, AND DISABILITY INCOME

	Yes	No
10. Within the past 5 YEARS has any person proposed for insurance:		
a. Had or been advised to have a surgical operation, electrocardiogram, x-ray or other diagnostic test?	☐	☑
b. Been in or advised to enter a hospital or other institution for consultation, examination or treatment?	☐	☑
c. Consulted or been examined by any physician or other practitioner?	☑	☐
d. Used sedatives, hallucinogenic or narcotic drugs *other than those prescribed by a physician* or received treatment for a drug habit?	☐	☑
e. Received treatment or advice for excessive use of alcohol?	☐	☑
11. Is any family member now pregnant?	☐	☑
12. Has any person proposed for insurance used any tobacco products within the past 12 months?	☑	☐
13. Has any person proposed for insurance ever been rejected or deferred for military service?	☐	☑
14. Is any proposed insured presently under observation or taking treatment?	☐	☑
15. Has any person proposed for insurance EVER had any indication, diagnosis, or treatment of:		
a. The brain or nervous system, including but not limited to dizziness, fainting, migraines, convulsions, paralysis, stroke, mental or nervous disorder?	☐	☑
b. The respiratory system, including but not limited to shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☑
c. The heart or blood vessels, including but not limited to chest pain, blood pressure, rheumatic fever, heart murmur, heart attack, varicose veins, or other disorder of the heart or blood vessels?	☐	☑
d. The gastro-intestinal tract, liver or pancreas, including but not limited to jaundice, intestinal bleeding, ulcer, colitis, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☑
e. The genito-urinary organs, including but not limited to sugar, *albumin, blood or pus in urine, stones or other disorder of* kidney, urinary bladder, or prostate?	☐	☑
f. The eyes, ears, nose or throat?	☐	☑
g. Diabetes or elevated blood sugar, thyroid or other glandular disorder, including but not limited to lymph glands?	☐	☑
h. Neuritis, arthritis, gout, disorder of the muscles or bones, including but not limited to spine, back, or joints?	☐	☑
i. Complications of pregnancy and/or cesarean section?	☐	☑
j. Deformity, lameness or amputation?	☐	☑
k. Cyst, tumor, cancer, or growth of any kind?	☐	☑
l. Allergies, anemia or other disorders of the blood?	☐	☑
m. Disease or disorder of the reproductive organs or breasts?	☐	☑
16. Has any person proposed for insurance EVER been diagnosed or treated for any disorder or dysfunction of the blood system or immune system including but not limited to Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or Lymphadenopathy Syndrome?	☐	☑

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 10 THRU 16

Ques. No.	Person No.	Nature of Injury, Sickness, Disease, Impairment or Physical Condition	Date	Hospitalization Required? Yes	Hospitalization Required? No	Hospitalization Required? Date	Surgery Performed? Yes	Surgery Performed? No	Surgery Performed? Date	Name and Address of Physician and Hospital
14	1	Left Complete Vision	1996		✓			✓		Dr. Hayden

17a. List below all life, health and disability income insurance currently in force or that you have applied for in the last six months. **If none, state none.**

#	COMPANY NAME	TYPE of COVERAGE	LIFE INS. AMOUNT	DISABILITY BENEFIT AMOUNT	DISABILITY BENEFIT PERIOD	DISABILITY ELIM. PERIOD	Status Applied for	Status In Force Standard	Status In Force Substandard
1	None						☐	☐	☐
2							☐	☐	☐
3							☐	☐	☐
4							☐	☐	☐
5							☐	☐	☐

b. Which of the above will be changed, terminated, not taken, or replaced by coverage(s) that you are applying for on this application. ☐ **If None, check here.**

FROM 17.a	DATE OF CHANGE OR TERMINATION	DETAILS-IF CHANGE

6980-AG (794)

T1000031

SECTION D — COMPLETE THIS SECTION FOR LIFE AND DISABILITY INCOME

18. Annual earned income from personal services (after business expenses, if any) as you reported on your Federal Income Tax Return

	Last Year	Current Year (est.)
Salary, Draw, Professional Fees	$	$
Other (describe):	$	$
TOTAL	$	$

19. List your unearned income from investments or other sources (e. g., dividends, interest, net rental income, pensions, alimony, etc.):

Last Year	Current Year (est.)
$	$

SECTION E — COMPLETE THIS SECTION IF APPLYING FOR BUSINESS OVERHEAD EXPENSE RIDER

20. a. What is the Applicant's share of the overhead expenses? ________ %

b. List below the total monthly expenses of the business entity for which you are liable:

Rent/Mortgage Payment	$	Vehicle, Machinery, Equipment Rental	$	Interest on Business Loans	$
Utilities (Electricity Telephone, Heat)	$	P & C Insurance	$	Employees Salaries (other than family)	$
Ad Valorem Taxes on Business Equipment Property	$				

TOTAL COVERED $
Other Expenses $
TOTAL EXPENSES $

21. a. How many people are employed by this company? (Include the Applicant in the total)

Owners: Full-time ________ Part-time ________
Employees: Full-time ________ Part-time ________

b. Do any of the above include spouse, parent, son, daughter, brothers or sisters of you or your spouse? .... Yes No

If yes, indicate number of Owners ________ Employees ________

22. The Applicant's company is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation
☐ S Corporation-Date of Election ___ / ___ / ___ (Mo. Day Yr.) ☐ Other (Specify) ________

SECTION F — COMPLETE THESE TWO QUESTIONS IF CHILD LIFE INSURANCE IS APPLIED FOR

1. If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives: (Attach additional page with information)

2. How much life insurance is carried by: (a) Father ________ (b) Mother ________ (c) If this application is greater than (a) or (b) above: (Attach additional page with explanation)

TRUE AND COMPLETE

I understand each of the questions above and affirm that the recorded answers and statements are true and complete to the best of my knowledge and belief, and all information given to the agent has been recorded correctly and in its entirety.

____
Signature of Applicant

DECLARATION AND AGREEMENTS

I agree that: (a) this Application will form a part of the contract; (b) the agent does not have the authority on behalf of the Company to accept risks or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; and (c) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting insurability are and have remained as described herein and the first premium has been paid in full. I understand any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is subject to criminal and/or civil penalties. I hereby acknowledge receipt of a copy of the Fair Credit Reporting Act and Medical Information Bureau notices.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give PFL Life Insurance Company, or its reinsurers, any such information. PFL Life Insurance Company may also release information about me to its reinsurer. I authorize PFL Life Insurance Company to obtain an investigative consumer report on me. A photographic copy of this authorization shall be as valid as the original.

I have truly and accurately recorded the information as supplied by Applicant and family members.

____
Signature of Licensed Agent

1285
____
Agent's Number

$ 751.20
____
Amount Collected By Agent

I UNDERSTAND THAT COVERAGE IS NOT EFFECTIVE UNLESS AND UNTIL APPROVED AND ISSUED BY THE COMPANY

Dated at ________ (City) ________ (State) ________ (Month) ________ (Date) 19__ (Year)

Signed X ________________________ Applicant (For and in behalf of above) ________ Social Security #

Signed X ________________________ Spouse ________ Social Security #

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CHECK MUST ACCOMPANY APPLICATION

TI000032